UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

JESSICA HODGES, et al.	)	
	)	
Plaintiffs,	)	
	)	Case Number: 4:22-cv-00067-WTM-CLR
vs.	)	
	)	
CHATHAM COUNTY, GEORGIA, et al.	)	
	)	
Defendants.	)	

EXHIBIT 2

CORRECTHEALTH	CHATHAM COUNTY DETENTION CENTER POLICY AND PROCEDURE		
PROCEDURE IN THE EVENT OF AN INMATE DEATH		Number	CTMJ-A-09.0
		Original	January 2017
		Previous	November 2017
Section	A - Governance and Administration	Current	January 2019
References	NCCHC JAIL 2018: J-A-09 (I); ACA 2008: 4-ALDF-4D-12; 4-ALDF-4D-23.		

POLICY: *All inmate deaths will be reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures or practices are warranted; and to identify issues that require further study. This will include all inmate deaths, whether on-site or in another location while under the custody of the Client. Upon notification that an inmate has died within one (1) week of release, the patient care rendered inside the facility and the circumstances surrounding the death (if available) will also be reviewed.*

PROCEDURE:

1. Notification Responsibilities (Any death while in custody)
    a. When an inmate death occurs the on-site healthcare staff will ensure that the Health Services Administrator and the on-call provider are immediately notified.
    b. The Health Services Administrator will immediately notify the following:
        i. The Executive Medical Director
        ii. The Facility Medical Director
        iii. Executive Director of Clinical Services
        iv. CorrectHealth Chief Legal officer
    c. The Health Services Administrator will also contact the Facility Administrator/designee to provide any information related to the inmate's death. If requested, the Health Services Administrator will facilitate communication between the Facility Medical Director and the Facility Administrator.
    d. CorrectHealth Clayton County staff will not be responsible for notifying next-of-kin, the medical examiner, criminal investigation division or other governmental agencies, unless specifically instructed to do so by Facility Administration.
2. The Health Services Administrator will verify staff compliance with site specific procedures related to the death of an inmate through active chart review and by participating in the Mortality Review conducted by the CorrectHealth Executive Committee.
3. CorrectHealth Chatham County Detention Center staff will initiate resuscitative measures in all cases of cardiopulmonary arrest in accordance with the site-specific Emergency Response Plan.
4. Each staff member who provides care during the resuscitation effort will document his/her individual actions in the Emergency Response chart note in the EMR prior to the end of their shift and before leaving the facility.
5. Staff will cooperate with any investigation conducted as a result of an inmate death.
6. The Inmate Health Record
    a. The original health record of the inmate in the EMR will be locked by CorrectHealth Director of IT as directed by CorrectHealth Legal Counsel. The Health Services Administrator will sequester paper records (in a secure on-site location).
    b. This original electronic record may be reviewed by Facility Administration, the Medical Director, the Health Services Administrator, the President, the Executive Medical Director, the CorrectHealth Executive Committee, the Executive Director of Clinical Services. Others may review the record as authorized by these individuals.

c. No other individuals or agencies will be given copies of the medical record unless authorized by Facility Administration or by CorrectHealth Chief Legal Officer.

7. Additional Health Services Administrator Responsibilities:
   a. If an autopsy is conducted, the Health Services Administrator will facilitate procurement of the report through Facility Administration. This report will be forwarded to the CorrectHealth Chief Legal Officer for inclusion in the mortality review.
   b. Critical Incident Stress Management will be offered to all healthcare staff that provided care to the deceased inmate. The Director of Human Resources may assist the Health Services Administrator in this process.
   c. If the death occurred on-site, the Health Services Administrator may conduct a formal critique of this sentinel event as an actual man-down event according to the Emergency Response Plan policy and procedure.
   d. The Health Services Administrator will be responsible for the implementation of any Corrective Action Plan developed as a result of the mortality review or the formal man-down critique.
8. Mortality Review
   a. An multidisciplinary clinical mortality review will be conducted within 30 days of the incident on all:
      i. Deaths of inmates housed on-site
      ii. Deaths of inmates in custody, but located off-site (hospital, another facility, work release)
      iii. Deaths of individuals within one week of release from custody
   b. This review will be scheduled by the Health Services Administrator and Medical Director in conjunction with the CorrectHealth Executive Committee.
   c. The review will include key clinical, administrative and security personnel.
   d. The mortality review will evaluate administrative and clinical aspects surrounding the death. When suicide is the cause of death, a psychological review will be included in the overall process.
   e. If multiple deaths occur at one facility, a special mortality review will be conducted to determine whether any patterns require further study.
   f. The results of the mortality review are discussed with treating healthcare staff.
   g. Any Corrective Action Plan developed as a result of the mortality review will be implemented by the Health Services Administrator through the CQI process as directed by the CorrectHealth Executive Committee and Executive Director of Clinical Services.
   h. Detailed documentation of the mortality review will be retained by the CorrectHealth Executive Committee. If requested, the CorrectHealth executive Committee can provide verification that a mortality review was conducted according to Company Policy and Procedure.
9. Administrative Reviews
   a. Administrative review of correctional and emergency response actions surrounding an inmate's death will be done through the jail administration.
10. Psychological Autopsy
   a. All deaths by suicide will have a written reconstruction of an individual's life with an emphasis on factors that led up to and may have contributed to the death is conducted by a mental health professional within 30 days of the death.
11. A log is maintained for all reviews.